community in which you live, and your economic status. Currently, one seventh of all Americans, 42 million people, lack insurance and suffer unnecessary illness and premature death; a disparate number of these people are racial or ethnic minority Americans.

Despite being first in spending, the World Health Organization has ranked the United States 37th among all nations in terms of meeting the health care needs of its people. Furthermore, despite the numerous advances that have been made in health care over the decades, racial and ethnic minority Americans continue to suffer disproportionately from many severe health problems and have higher mortality rates than whites for many treatable health conditions. Diabetes strikes African Americans 70% more often than Caucasian Americans; Hispanic Americans twice as often as whites; the diabetes rate for Native Americans is even higher. striking members of this community 180% more often than Caucasian Americans. African Americans are 40% more likely to die from coronary heart disease and 35% more likely to die from cancer than Caucasian Americans.

It is because of these glaring disparities, the NAACP strongly supports the efforts of the Congressional Black Caucus, the Congressional Hispanic Caucus and the Congressional Asian/Pacific Islander Caucus to address these problems with the introduction of comprehensive legislation which expands health care access, improves health care quality, strengthens key academic institutions and research centers, and bolsters the health care infrastructure in underserved communities.

Given the importance of this legislation, and the NAACP's historic mission to eliminate racial disparities wherever they exist and to promote affordable, adequate health care among racial and ethnic minorities it is our honor, as well as our duty as some might argue, to support this legislation in the strongest terms possible. Thus the NAACP is committed to using all of our available resources to see this bill's quick enactment.

Thank you for your leadership in this area: I look forward to working with you toward our common goal. Should you have any questions, please feel free to contact us.

Sincerely,

HILARY O. SHELTON,
Director.

AMERICAN PUBLIC HEALTH ASSOCIATION,
Washington, DC, March 7, 2006.

Hon. DANIEL AKAKA,
U.S. Senate,
Washington, DC.

DEAR SENATOR AKAKA: On behalf of the American Public Health Association (APHA), the oldest, largest and most diverse organization of public health professionals in the world, dedicated to protecting all Americans and their communities from preventable, serious health threats and assuring community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States, I write in support of S. 2305. This legislation would repeal the provision of the Deficit Reduction Act of 2005 that would require documentation evidencing citizenship or nationality as a condition for being enrolled in the Medicaid program.

APHA strongly supports efforts to reverse the cuts and changes to the Medicaid program included in the Deficit Reduction Act of 2005 that jeopardize the health of our nation's most vulnerable, including Medicaid beneficiaries. Several Medicaid reforms included in the bill have unintended and severe consequences and will not result in the projected cost savings. Of note is the provision in the legislation that requires individuals to present citizenship or residency documentation in order to enroll in the Medicaid program. Although not its intent, this provision is expected to have a devastating impact on the health coverage and status of native-born citizens who are in every way eligible for the Medicaid program.

Citizenship and verification requirements in Medicaid and the State Children's Health Insurance Program have been proven to reduce enrollment in the programs among the eligible population. The provision included in the Deficit Reduction Act of 2005 that would require individuals to present documentation proving citizenship or nationality in order to enroll in the Medicaid program is expected to cause thousands of Medicaid beneficiaries who are native-born citizens but do not have a birth certificate or passport in their possession to join the country's uninsured ranks. This provision will likely exacerbate existing racial/ethnic and rural/urban health disparities, as it is expected to disproportionately affect elderly African Americans, individuals residing in rural areas and Katrina survivors, many of whom were not born in a hospital or lost such documentation during Hurricane Katrina or other life tragedies. Also, Medicaid beneficiaries and applicants with mental disorders will likely be adversely affected, as the provision did not include exceptions for any populations, including those with severe physical or mental impairments such as Alzheimer's disease.

Therefore, there is the need to now take a vital step to protect the public's health and repeal this harmful provision included in the Deficit Reduction Act of 2005. We thank you for taking a leadership role in doing so, and look forward to working with you as this legislation moves forward.

Sincerely,

GEORGES C. BENJAMIN,
Executive Director.

LIHEAP FUNDING

Mr. FEINGOLD. Mr. President, I am pleased that the Senate has finally passed legislation to help hard-working families that have been grappling with skyrocketing energy costs for far too long. My colleagues from Maine and Rhode Island, Senators SNOWE and REED, have worked diligently to get LIHEAP legislation to the Senate floor and I thank them for their commitment. I must note, however, that the funding approved by the Senate yesterday is too little, too late. As we move forward with the appropriations process for fiscal year 2007, I will be urging my colleagues to fund the LIHEAP program at its fully authorized level so that next year my constituents don't again find themselves struggling to pay record heating bills while Congress turns a blind eye.

I would also like to respond to some of the concerns that I have heard a handful of my colleagues make during debate on whether we should increase the amount of LIHEAP funding available. A few members have spoken about the problem of earmarks and the need for responsible Government spending. I share concerns over earmarking and welcome the opportunity to work together on this issue so that we can look the public in the face and say that their tax dollars are being spent on the most meritorious projects. Increasing LIHEAP funding is not about earmarks—it is about helping our citizens with immediate and urgent needs.

AVIAN INFLUENZA IN AFRICA

Mr. FEINGOLD. Mr. President, the avian influenza, H5N1, virus has recently been detected for the first time in Nigeria. International health officials have long warned about the potential danger of avian flu spreading throughout the African continent, and it appears we are now one step closer to this danger becoming a reality.

While the threat of avian influenza is global, and needs to be addressed here in the United States, it is of particular concern in Africa. Many governments in Africa are unequipped to effectively deal with an outbreak, which requires early detection, quarantining, and culling of affected bird populations. And although there are no reports yet of humans contracting the disease in Nigeria, recent cases in Turkey and Iraq underscore the danger for people who live in close proximity to poultry, as is the case throughout much of Africa. In areas where birds, livestock, and people are in close contact, the risk of the virus mutating into a strain that can be transmitted between humans is increased. Additionally, immunocompromised individuals may be more susceptible to the disease, and it is unclear what effect avian influenza could have on populations already ravaged by HIV/AIDS, malaria, and other diseases. Finally, the already overburdened or underdeveloped health infrastructure in much of Africa may find itself unable to cope with a pandemic.

Avian flu is an international danger to which no country in the world is immune. While much attention has been paid to the problem in Asia, I am concerned that the international community has not prepared sufficiently for an outbreak in Africa. Particularly worrisome is the amount of time it apparently took for the outbreak in Nigeria—a member of the recently formed West African Network on Avian Influenza, and presumably better prepared than many other African nations to deal with the threat of avian influenza—to be reported to international health authorities.

It is essential that the administration develop a plan for managing a wide-scale outbreak of avian influenza in Africa, as well as developing contingency plans relating to the impact that an outbreak of avian influenza may have diplomatically, economically, and security-wise in each major region of the continent. I also urge the administration to develop plans to support organizations like the African Union to develop information-sharing mechanisms and a clearinghouse of information related to initial reporting, initial impact, mitigation efforts, and management mechanisms to prevent the spread of the virus, beyond the initial efforts that have been made through